BTL Sept 01 28/8/01 12:54 pm Page 24

Dr Darrin Baines

Breath of fresh air

The prescribing landscape is changing as a powerful new force enters the fray

There's a new kid on the block: the medicines manager. Within primary care, those in the know are talking about this new breed of super strength pharmaceutical adviser.

By 2004, every Primary Care Trusts (PCT) in England will have one and similar species will shortly be appearing in both Scotland and Wales.

The Government has a plan for the future of pharmacy and pharmaceutical care, and medicines managers have the task of promoting better and more efficient use of medicines.

The message for pharma is crystal clear; forget about old-style pharmaceutical advisers, your future lies in this new breed of drugs gatekeepers

The National Plan for Pharmacy (subtitled *Pharmacy in the Future*), published in September 2000, announced the Government's intention to radically reform NHS pharmacy in England.

Since this date, bodies in Northern Ireland, Scotland and Wales have followed suit and issued similar plans.

The main aims of *Pharmacy in the Future* are to:

- improve medicines usage
- promote access to pharmacy services
- redesign local pharmaceutical services
- ensure high quality pharmaceutical care

To make these proposals law, the Health and Social Care Bill was introduced into the House of Commons in December 2000 and was successfully enacted just before the general election.

Therefore, it won't be long before the pharmaceutical industry sees some changes to the structure and operation of the markets for its products.

The prescribing triumvirate

Since the introduction of the NHS in 1948 the ways drugs are prescribed and dispensed have not fundamentally changed.

General practitioners armed with their prescription pads have had sole rights to prescribing with community pharmacists at the other end, with conveniently located retail outlets, dispensing exactly what the doctor orders.

Caught in the middle are patients with their pieces of paper listing their drugs, which must be physically carried between prescriber and dispenser before they receive their medicine.

This basic process, which all users of the NHS know well, has created problems.

Firstly, the prescriber and the dispenser, usually located in separate premises, have no means of direct communication unless one party decides to pick up the phone.

Next, the NHS has no record of whether the doctor or the pharmacist are doing a good job and improving health outcomes.

Finally, patients receive no automatic support from the system supplying them drugs and they are often left to their own devices, effectively making them free to decide whether to collect their medicines or not.

Futurescape

As the Government spends millions and millions of pounds on pharmaceutical products every year, with no measurement of its effects, some ministers, civil servants and HM Treasury officials decided changes were in order.

They devised *Pharmacy in the Future* (see www.doh.gov.uk/pharmacyfuture), to do three things:

- introduce outcome measurements into pharmacy as part of the clinical governance agenda

BTL Sept 01 28/8/01 12:54 pm Page 25

- improve the pharmacy skill mix, making better use of trained pharmacists in overseeing medicines usage
- move from national dispensing fees to local contracting of pharmacy services through Local Pharmaceutical Services (LPS) scheme.

If successful, these changes represent a radical reform of pharmacy services within the NHS, and to ensure they are successful the Government plans to utilise this newly created group of publicly funded, specially-equipped pharmacists, otherwise known as medicines managers.

The old system of doctor prescribing and pharmacist dispensing will soon begin to disappear

Conditions for birth

Since the early 1990s, health authorities (HAs) have employed pharmacists to audit general practitioner (GP) prescribing data using Prescribing Analysis and CosT (PACT) data.

As the decade progressed, the number of such advisers grew, many employed by the newly created Primary Care Groups, later Trusts.

In parallel to this trend, during the mid-1990s, some general practitioners began to employ NHS-funded pharmacists in their practices to audit and improve their prescribing behaviour.

Although many claim otherwise, a large number of pharmacists have already been employed in primary care because they have been effective at helping control expenditure on drugs by family doctors.

Despite the rhetoric that advisers were primarily employed to promote prescribing quality (not to control costs), most 'improvements' in drug use have been aimed at switching to cheaper, therapeutically equivalent products.

Therefore, pharmaceutical advisers became the friends of cost-conscious managers and doctors in primary care, but some commentators have argued they have done little for patients or pharma.

A new breed

This 'cost-conscious primary care' environment is the perfect breeding ground for this new strain of *uber*-pharmacists. However, medicines managers will differ from their predecessors as they will have different, more effective powers.

Whilst most pharmaceutical advisers worked as support staff for local doctors, medicines managers on the other hand will have the power to create their own systems for supplying drugs.

They will be able to choose who, apart from general practitioners, can prescribe and dispense the medicines. For example, nurses are now able to prescribe certain medicines, pharmacists can supply products under Patient Groups Directions (PGDs) and specially created bodies will soon be able to bid to provide NHS pharmacy services under the auspices of the LPS scheme.

In this new melting pot, it will be the job of medicines managers to co-ordinate the change process so new types of professionals – including nurses, midwives, health visitors, optometrists, pharmacists, chiropodists, radiographers, orthoptists, physiotherapists and ambulance paramedics – have greater roles in delivering pharmaceutical care.

With these new powers to change the age-old way that medicines are prescribed and dispensed, the implications for pharma companies are clear; as NHS pharmaceutical services are gradually reformed, companies will have to become more sophisticated at identifying who exactly within the system controls the use of their products.

In this new world, old marketing techniques will still be effective, but pharma companies will have to expend more time and effort using them on a growing band of drug prescribers and suppliers.

As the chaos grows, medicines managers will be one of the few groups of professionals who will maintain an overview of exactly what is happening on the ground in the localities.

Pharmaceutical companies will need to target and communicate with these individuals in ways that protects or grows their market share.

LPS pilots

One major piece of reform introduced as part of the initiatives included in *Pharmacy in the Future* is the introduction of Local Pharmaceutical Services pilots.

These pilots will be designed to change the ways in which local pharmacy services are delivered and will have the following key features:

- signed contracts between the local 'purchaser' and 'providers' of pharmacy services
- performance monitoring systems, with agreed quality indicators for services provided
- specially designed incentives, budgets and remuneration for each provider
- annual reviews of performance by the purchasing agency
- monthly fixed payments for providers, which can be modulated at year-end if performance targets are not met.

As the above suggests, the way in which pharmacy services are contracted, monitored and remunerated will radically change under LPS arrangements.

With the introduction of these LPS changes, pharmacists will become an empowered group, with a much greater level of control over the use of medicines within the NHS.

As a consequence, the professionals who run local LPS schemes will, effectively, become the key medicines managers in their localities and be given enhanced powers because of their status.

Implications for pharma

The pharmaceutical industry has challenging and exciting times ahead of it.

The traditional system of doctor prescribing followed by pharmacist dispensing will soon fade from the primary care landscape.

In its place, will burgeon a new selection of healthcare professionals, able to supply medicines to patients in a whole range of new settings, not just the general practitioner's surgery.

For the pharmaceutical industry, such reforms will result in greater effort and resources being required to identify key decision-makers in each local area.

Sales may not increase massively but marketing budgets will almost certainly need to grow or be reviewed and spent in different ways.

However, before companies rapidly disband their sales forces and employ more and more liaison staff, they should learn more about the new agenda.

For example, pharmaceutical advisers and other potential medicines managers are routinely attending national implementation conferences and similar educational events in an attempt to discover more about the future that lies ahead.

By being informed, pharmacists and other NHS personnel believe that they can help shape the changes ahead.

Similarly, savvy pharmaceutical companies that wish to shape pharmacy future should jump on the bandwagon early and start learning more about the Government's new plans alongside their NHS colleagues.

Indeed, once the new buzzwords have been learnt, the new hot contacts made and the new, dynamic relationships formed, pharmaceutical companies may well find doing business with medicines managers more profitable and pleasurable than the traditional doctor-focused selling in primary care.

THE AUTHOR

Dr Darrin Baines is the director of NHS and pharmaceutical educational services provider, medM Ltd. He can be contacted at director@ medm.co.uk